EPI-LOG

Communicable Disease and Epidemiology News
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Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.
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SARS Update

At the time the *Epi-Log* went to print, there was one confirmed, and two suspect SARS cases reported in Guangdong Province in southern China. No signs and symptoms of SARS-like illness have been reported among close contacts of these cases. In light of these reports, the CDC is recommending that U.S. physicians maintain a greater index of suspicion of SARS in patients who require hospitalization for radiographically confirmed pneumonia or acute respiratory distress syndrome (ARDS) AND who have a history of travel to Guangdong Province (or close contact with an ill person with a history of recent travel to Guangdong Province) in the 10 days before onset of symptoms. Such cases should be reported promptly and SARS isolation precautions should be used.

On January 8, 2004, the CDC released an update to the **"Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)".** This Supplement consolidates and updates the previous guidelines and provides new information to guide evaluation and management of potential SARS patients in hospitals and outpatient settings. This document can be found at: www.cdc.gov/ncidod/sars/clinicalguidance.htm.
Some changes since the last version was released include:

- Healthcare facilities are highly encouraged to coordinate SARS preparedness activities with public health, including surveillance, reporting, monitoring, and management of exposed patients and healthcare workers, including implementation of out-of-hospital isolation for patients and activity restrictions for exposed health care workers.
- The term "universal respiratory etiquette" has been changed to "respiratory hygiene/cough etiquette." The recommendation to identify persons with respiratory infections early in the clinical encounter and screen for SARS risk factors remains a priority. Because patients with respiratory infections may not present with fever, the document clarifies that the recommended practices apply to all patients with symptoms of a respiratory infection.
- Current screening recommendations state that children hospitalized for radiographically confirmed pneumonia need not be screened for potential SARS-CoV disease, unless circumstances suggest that a child might be at high risk for exposure to SARS-CoV. Should person-to-person SARS transmission be reported in the world, screening for children should as for adults.

CDC also updated the recommendations in "**Clinical Guidance on the Identification and Evaluation of Possible SARS-CoV Disease among Persons Presenting with Community-Acquired Illness"** (www.cdc.gov/ncidod/sars/clinicalguidance.htm). During the 2003 global epidemic, SARS-CoV caused high levels of morbidity and mortality among healthcare personnel and disrupted healthcare delivery systems, leading in some instances to closure of hospitals. Rapid implementation and adherence to infection control measures proved essential for controlling transmission in healthcare settings. This document is designed to assist healthcare providers in controlling SARS-CoV transmission.

Influenza Update

Influenza activity in Washington is no longer widespread, but is categorized as regional.

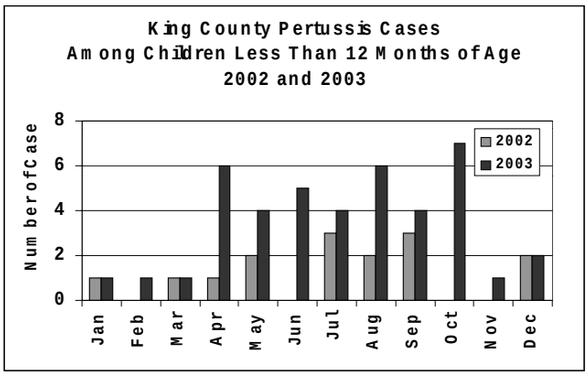
On a national level, the number of states reporting widespread flu activity continues to decline, and the number of visits for influenza-like illness has declined throughout the US, though the pneumonia and influenza mortality continued to exceed the epidemic threshold as of January 10th.

Internationally, an outbreak of avian influenza with a high mortality rate is occurring in Vietnam. Healthcare providers should identify and report patients hospitalized with unexplained pneumonia, ARDS, or severe respiratory illness AND who have traveled to Vietnam, South Korea, and Japan within 10 days from onset of symptoms. All such patients should be tested for influenza virus infection, including viral culture of nasopharyngeal and throat swabs.

Pertussis Up in 2003, Especially Among Infants <6 Months of Age

Between 2002 and 2003, there was an 82% increase in the total number of pertussis cases reported in King County, from 282 in 2003 to 155 in 2002. Most alarming is a three-fold increase in pertussis among infants less than six months old (38 in 2003 versus 12 in 2002). The increase in pertussis among infants <6 months is especially important because these infants are much more likely to develop severe illness and require hospitalization than older children and are too young to have completed the initial pertussis vaccine series (given at 2, 4 and 6 months). Of the 38 infant cases <6 months in 2003, twenty (53%) were hospitalized, with lengths of stay of up to 26 days (median stay was 7 days).

The pertussis vaccine does not prevent all pertussis infections, and the immunity conferred by the vaccine wears off approximately 10 years after the last booster dose, usually given prior to Kindergarten entry. The value of pertussis vaccine is that it is effective in preventing pertussis-related severe illness and death among infants. Children, teenagers and adults who have been fully immunized for pertussis, may still develop "atypical" or milder pertussis infection, and often present with only a persistent cough, often worse at night.



No pertussis vaccine is licensed for children over the age of six years; however available data show that the acellular pertussis vaccine is safe and effective in older children, teenagers, and adults, and is recommended in Canada, for example. In the absence of a pertussis vaccine for these older age groups in the U.S., the best way to prevent pertussis in infants is prompt diagnosis and preventive treatment of close contacts of cases.

Household members and other close contacts of young infants (including health care providers), and especially members of households that include an expectant mother nearing her delivery date, should seek medical evaluation for coughs persisting for two weeks or longer. Young infants with pertussis may present with only breathing, and/or feeding difficulties, so providers should inquire into whether any close contacts of these infants have had a persistent cough illness.

Epidemiology and Prevention of Vaccine-Preventable Disease Course Begins February 19, 2004

Public Health-Seattle & King County and the Region X Public Health Service are co-sponsoring the CDC satellite course "Epidemiology and Prevention of Vaccine-Preventable Diseases" on four consecutive Fridays, February 19, February 26, March 4 and March11, 2004. All four sessions of this interactive broadcast will be held from 9 AM to 12:30 PM in the Blanchard Plaza Building at 6th and Blanchard in downtown Seattle. Register early as space is limited.

For each session continuing education credit will be offered for various professions based upon three hours of instruction. Each participant also receives a copy of the CDC book Epidemiology and Prevention of Vaccine Preventable Diseases" (also known as "The Pink Book). The course fee is $20. Please contact us if payment is not possible. To order a registration form, call Tiffany Acayan at (206) 205-5812 (subscribers to *The VacScene* newsletter will automatically receive a registration form in the mail).

Disease Reporting

AIDS/HIV ..... (206) 296-4645

STDs ..... (206) 731-3954

TB (206) 731-4579

All Other Notifiable Communicable Diseases (24 hours a day) .... (206) 296-4774

Automated reporting line for conditions not immediately notifiable.....(206) 296-4782

Hotlines

Communicable Disease ..... (206) 296-4949
HIV/STD ..... (206) 205-STDS

Online Resources

Public Health Home Page: www.metrokc.gov/health/
The *EPI-LOG*: www.metrokc.gov/health/providers
Subscribe to the Public Health Communicable Disease listserv (PHSKC INFO-X) at:
http://mailman.u.washington.edu/mailman/listinfo/phskc-info-x

Reported Cases of Selected Diseases, Seattle & King County 2003

	Cases Reported in December		Cases Reported Through December	
	2003	2002	2003	2002
Campylobacteriosis	24	22	248	284
Cryptosporidiosis	2	7	37	28
Chlamydial infections	483	429	5,169	4,471
Enterohemorrhagic *E. coli* (non-O157)	0	0	1	0
***E. coli* O157: H7**	1	4	39	27
Giardiasis	5	15	109	156
Gonorrhea	96	127	1,351	1,461
***Haemophilus influenzae* (cases <6 years of age)**	0	0	1	0
Hepatitis A	0	3	30	31
Hepatitis B (acute)	2	1	36	31
Hepatitis B (chronic)	46	63	524	586
Hepatitis C (acute)	0	0	8	12
Hepatitis C (chronic, confirmed/probable)	74	126	855	1,516
Hepatitis C (chronic, possible)	27	28	247	410
Herpes, genital (primary)	89	39	691	650
HIV and AIDS (includes only AIDS cases not previously reported as HIV)	47	33	520	557
Measles	0	0	0	0
Meningococcal Disease	2	4	5	21
Mumps	0	0	0	0
Pertussis	12	16	282	155
Rubella	0	0	0	2
Rubella, congenital	0	0	0	0
Salmonellosis	18	18	222	194
Shigellosis	0	11	84	72
Syphilis	7	12	85	52
Syphilis, congenital	0	0	0	0
Syphilis, late	4	3	51	44
Tuberculosis	14	17	154	158

The *Epi-Log* is available in alternate formats upon request.